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Is Hypnotherapy an Effective Treatment for Depression?

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A SELECTIVE EVIDENCE BASED MEDICINE REVIEW

In Partial Fulfillment of the Requirements For

The Degree of Master of Science

In

Health Sciences – Physician Assistant

Department of Physician Assistant Studies
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ABSTRACT

Objective: The objective of this EBM paper is to determine whether or not hypnotherapy is an effective treatment for depression.

Study Design: Review of two English language randomized controlled trials and one case study published in 2007, 2009, and 2010.

Data Sources: Two randomized controlled trials and one case study reviewing the effectiveness of hypnotherapy on depression were found using PubMed, Medline, and CINAHL.

Outcomes Measured: Depression was measured through the Beck Depression Inventory (BDI-II), which is a 21-question multiple choice self-report inventory based on scores of 0-63, with higher scores signifying more severe depressive symptoms. Anxiety was measured through the Beck Anxiety Inventory (BAI) and hopelessness was measured through the Beck Hopelessness Scale (BHS).

Results: In a randomized controlled trial by Alladin and Alibhai, hypnotherapy produced significant improvement in BDI-II, BAI, and BHS scores from baseline. In another study by Dobbin et al, hypnotherapy was significantly more effective than antidepressant treatment on depression. A case study by Lorio and Torti shifted the view of depression from an interpersonal view to include the role of family and cultural influences through hypnotherapy of the patient and their family, which resulted in a decrease of depressive symptoms.

Conclusion: The results of the two randomized controlled trials and one case study demonstrate that hypnotherapy is an effective treatment for depression.

Keywords: Depression, Hypnotherapy, Hypnosis

INTRODUCTION

Depression is a chronic illness with an increasing incidence over the last century in the United States as well as internationally. Depression currently affects over 21 million Americans.¹ The incidence of depression in the United States is 20% in females and 12% in males.² Depression costs an estimated \$83.1 billion/year in the US.³ The number of health care visits with depression as a primary diagnosis was estimated to be 7.9 million/year.⁴

The exact cause of depression is relatively unknown. However, current evidence suggests that the cause is related to neurotransmitter imbalance, with serotonin being an important factor, but also including norepinephrine, dopamine, glutamate, and brain-derived neurotrophic factor. Stressors and genetic factors also play an important role in the development of depression.² Patients with depression may present with dysphoric mood, anhedonia, irritability, or difficulty concentrating. They may also present with somatic complaints such as fatigue, headache, abdominal pain, or changes in weight.² The diagnostic and statistical manual of mental disorders (DSM-IV) lays out the criteria for diagnosing depression. A major depressive episode must include a depressed mood and a loss of interest (anhedonia) plus at least three of the following symptoms for at least a 2-week period: sleep disturbance, appetite changes, psychomotor agitation, fatigue or loss of energy, feelings of worthlessness, diminished ability to think or concentrate, and suicidal thoughts.²

Current standard therapy for depression includes pharmacotherapy, psychotherapy, and electroconvulsive therapy. Psychotherapy treatments include cognitive-behavioral therapy (CBT), hypnotherapy, interpersonal therapy or counseling, and family or group therapy. Cognitive behavioral therapy is a type of treatment that focuses on changing maladaptive thinking in order to improve affect and behavior. Electroconvulsive therapy, which is usually

reserved as a treatment for severe depression, involves electric currents being passed through the brain, triggering a brief therapeutic clonic seizure, which causes a change in brain chemistry that is thought to improve symptoms of mental illnesses.⁵

While antidepressant medication and cognitive-behavioral therapy are used as first-line treatments for depression, hypnotherapy has also been considered a treatment option. During a hypnotherapy session, as a patient is brought into deeper levels of consciousness, their heart rate, respiration, and blood pressure decrease. When the patient has reached the deepest level of consciousness, he or she can access forgotten memories, painful events, and neglected emotions. The hypnotherapist “assists the patient with constructing new, healthier thought processes and behaviors to use when mentally encountering the depressive events.”⁶

This paper evaluates two randomized controlled trials and one case study on the effectiveness of hypnotherapy for the treatment of depression.

OBJECTIVE

The objective of this systematic review is to determine whether or not hypnotherapy is an effective treatment for depression.

METHODS

Specific criteria were used in the selection of studies in the two randomized controlled trials. In the RCT by Alladin and Alibhai⁷, selection of subjects included patients with chronic major depressive disorder based on the DSM-IV who have been treated with antidepressant medication for at least 6 months. Exclusion criteria included depressive patients with comorbid conditions such as schizophrenia, schizoaffective disorder, current substance abuse, eating disorder, bipolar disorder, obsessive-compulsive disorder, organic mental disorder, pervasive developmental delay, or personality disorders. With this criteria in mind, 98 patients, 14 of

whom withdrew (leaving 84 patients at the end of the trial) were randomly assigned to a 16-week treatment of either cognitive-behavioral therapy (CBT) (n= 42) or cognitive hypnotherapy (CH) (n=42). After weeks 1 (baseline), 4, 8, 12, 16, 42, and 68, their depressive symptoms were measured using the Beck Depression Inventory (BDI-II), Beck Anxiety Inventory (BAI), and Beck Hopelessness Scale (BHS).⁷

The intervention used in this studied was cognitive hypnotherapy with the comparison group being cognitive-behavioral therapy. Cognitive hypnotherapy consisted of several techniques including hypnotic induction, ego-strengthening, expansion of awareness, positive mood induction, posthypnotic suggestions, and self-hypnosis. The focus of hypnotic induction was on relaxation, somatosensory changes, power of the mind, and increasing the patient's confidence. Expansion of awareness was utilized to amplify experiences of well-being and intensify positive feelings. Positive mood induction involved making a list of 10-15 happy experiences and practicing holding each experience in mind for approximately 30 seconds. The patient was encouraged to replace negative thoughts with a pleasant experience from their list. In this way, depressive pathways were replaced with pleasant pathways. Posthypnotic suggestions entailed positive reassurance that the patient will recover from depression. Finally, self-hypnosis was utilized by giving each patient a prerecorded audiotape of a self-hypnotic procedure that consisted of creating a positive frame of mind and ego-strengthening posthypnotic suggestions; each patient was instructed to listen to the tape at least once daily. The outcomes addressed were depressive symptoms, anxiety, and hopelessness, which were measured with the Beck Depression Inventory (BDI-II), Beck Anxiety Inventory (BAI), and Beck Hopelessness Scale (BHS). Cognitive-behavioral therapy in this study was based on the manual produced by Beck,

Rush, Shaw, and Emery, and is a psychotherapy that focuses on changing maladaptive thoughts in order to improve affect and behavior.⁷

The partially randomized preference study design by Dobbin et al⁸ evaluated 58 patients, who were allowed to choose either self-hypnosis or anti-depressants as a treatment for their depression over a period of 12 weeks. As a result, 50 patients chose self-hypnosis, 4 chose anti-depressants, and 4 were randomly assigned. Nine of the patients from the self-hypnosis group withdrew, leaving 41 patients in that group, with a total of 49 subjects in the trial. The subjects chosen were patients between the ages of 18 and 65 who have had a recent episode of depression (first attack or recurrence) or were about to have antidepressants prescribed to them. Exclusion criteria included patients with bipolar depression, psychoses, current alcohol and drug use, a depressive episode in the previous 6 months, or active suicidal ideation. The intervention addressed in this study was self-hypnosis, which was compared to antidepressant medication. The patients who chose self-hypnosis watched a short film that explained self-hypnosis, listened to the first recording, and were given the first CD out of the total 3 CDs, in which each CD included 4 sessions. The self-hypnosis was based on Integrated Mental Training, an audio-based program by Lars Eric Unestahl. The group who chose antidepressants were prescribed antidepressant by their general practitioners and instructed to fill their prescriptions and begin taking the medicine. The outcomes addressed were depressive symptoms, which were measured with the Beck Depression Inventory (BDI-II) and Brief Symptom Inventory (BSI).⁸

The case study by Loredio and Torti⁹ used systemic hypnotherapy on the depressed patient as well as his or her family in the same session. This systemic hypnotherapy attempted to understand depression as a complex series of interactions, where depression is not simply a personal emotional disorder but an interpersonal disorder that is influenced by relationship

patterns. The population studied included a 38-year-old husband and his depressed wife, a 61-year-old depressed dad and his 32-year-old son, and a 35-year-old depressed woman and her parents and sister. The outcomes addressed were depressive symptoms and overall well-being.⁹

Key words used in this search were “depression”, “hypnotherapy”, and “hypnosis”. All articles were published in peer-reviewed journals and in the English language. The author researched the articles in PubMed, Medline, and CINAHL. The articles were selected based on their relevance to the clinical question and on their importance of outcomes to patients (POEMs). Inclusion criteria included studies that were randomized, controlled, and included patient oriented outcomes. Exclusion criteria included studies that were dated before 1996 and whose outcomes were not patient oriented. The statistics used in the studies were ANOVA and *t*-scores.

Table 1: Demographics of included studies

Study	Type	# of pts	Age	Inclusion Criteria	Exclusion Criteria	W/D	Interventions
Alladin, Alibhai, 2007	RCT	98	23-47	Patients with chronic major depressive disorder who have been treated with antidepressant medication for at least 6 months	Depressive patients with comorbid conditions	14	Cognitive hypnotherapy and cognitive-behavioral therapy
Dobbin et al, 2009	Partially randomized preference study design	58	18-65	Patients who have had a recent episode of depression or who were about to have antidepressants prescribed to them	Depressive patients with comorbid conditions or active suicidal ideation	9	Self-hypnosis and anti-depressant medication
Loriedo, 2010	Case Study	3	35-61	Families with one or more members who is diagnosed with depression	N/A	0	Systemic hypnosis in a group setting

OUTCOMES MEASURED

The outcomes measured in these studies were depressive symptoms, anxiety, and hopelessness using the Beck Depression Inventory (BDI-II), the Beck Anxiety Inventory (BAI), and the Beck Hopelessness Scale (BHS). The BDI-II is a 21-question multiple choice self-report based on scores of 0-63, with higher scores signifying more severe depressive symptoms. A score of 0-13 indicates minimal depression, 14-19 indicates mild depression, 20-28 indicates moderate depression, and 29-63 indicates severe depression.¹⁰

Depressive symptoms were also measured using the Brief Symptom Inventory (BSI), a 53-question self-report that assesses psychological distress and psychiatric disorders through 9 subscales: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.¹¹ The BSI is scored based on the Global Severity Index (GSI), which helps “quantify a patient's severity-of-illness and provides a score for measuring the outcome of a treatment program based on reducing symptom severity.” In addition, SF-36, a 36-question health survey that measures physical and mental health, was used to quantify outcomes.¹² The SF-36 contains 8 scaled scores including vitality, physical functioning, bodily pain, general health perceptions, physical role functioning, emotional role functioning, social role functioning, and mental health.¹²

RESULTS

The two randomized control trials and one case study reviewed studied the effects of hypnotherapy on depression. In the RCT by Alladin and Alibhai⁷, ANOVA results indicated that there were no significant differences between Beck scores of participants in the CH or CBT treatment groups at baseline. At the termination of treatment (week 16), paired *t* tests demonstrated that subjects in the CH group had significantly lower BDI-II scores $t(41) = 15.9$,

$p < .001$, BAI scores $t(41) = 12.2$, $p < .001$, and BHS scores $t(41) = 12.4$, $p < .001$ compared to baseline. Participants in the CBT group also had significantly lower BDI-II scores $t(41) = 14.5$, $p < .001$, BAI scores $t(41) = 13.0$, $p < .001$, and BHS $t(41) = 13.3$, $p < .001$ at termination from baseline. However, it was discovered that the CH group displayed significantly greater changes in Beck scores at termination of therapy from baseline than the CBT group: BDI-II, $t(82) = -2.66$, $p = .009$; BAI, $t(82) = -3.22$, $p = .002$; BHS, $t(82) = -3.35$, $p = .001$. The CH group also presented with lower BDI-II scores at week 42 and week 68 than the CBT group, but the article failed to report if those results were significant. Moreover, the CH group displayed significantly lower anxiety than the CBT group at follow-up week 42, BAI $t(80) = -3.24$, $p = .002$, and week 68, BAI $t(72) = -3.08$, $p = .003$. There was no statistical significance of hopelessness scores between the CH and CBT group at week 42. However, the CH group displayed significantly lower hopelessness scores than the CBT group at week 68, $t(72) = -2.27$, $p = .026$. This indicates that participants in the CH group continued to listen to their self-hypnosis tapes even after treatment which helped in the maintenance of their reduced depressive symptoms.⁷ This study failed to report safety issues with hypnotherapy.

Table 2: Paired t test Results at Termination (week 16) Compared to Baseline of CH and CBT Groups

	BDI-II	BAI	BHS
CH	$t(41) = 15.9$, $p < .001$	$t(41) = 12.2$, $p < .001$	$t(41) = 12.4$, $p < .001$
CBT	$t(41) = 14.5$, $p < .001$	$t(41) = 13.0$, $p < .001$	$t(41) = 13.3$, $p < .001$

Table 3: Paired t test Results of CH compared to CBT Groups at Termination (week 16), Week 42, and Week 68.

	BDI-II	BAI	BHS
Termination (week 16)	$t(82) = -2.66$, $p = .009$	$t(82) = -3.22$, $p = .002$	$t(82) = -3.35$, $p = .001$
Week 42	Not reported	$t(80) = -3.24$, $p = .002$	No statistical significance
Week 68	Not reported	$t(72) = -3.08$, $p = .003$	$t(72) = -2.27$, $p = .026$

The partially randomized preference study design by Dobbin et al⁸ demonstrated that BDI and BSI scores were statistically significant between the self-hypnosis and anti-depressant medication groups at the termination of treatment (week 12), BDI $p = .004$, BSI $p = .012$, with self-hypnosis being significantly more effective than antidepressant medication in the treatment of depression. Tables 4 and 5 illustrate BDI and BSI scores at intake and at the end of treatment. The self-hypnosis and antidepressant medication group were also compared using the SF-36, which demonstrated significant differences in general health ($p = .012$, 95% CI for effect size 5.1 and 37.9) and vitality ($p = .003$, CI 10.3 and 46.6). Because the groups were not randomized but selected by preference of the participants, there was “some degree of adjusting for baseline factors in the analysis using multiple regression.” However, the treatment remained statistically significant, and the results from the t test were not explained by imbalance at baseline. The two randomized self-hypnosis and antidepressant medication groups could not be compared because there were only 4 subjects across the two groups. There were no adverse events with either self-hypnosis or anti-depressant medication subjects and no hospital admissions.⁸

Table 4: BDI and BSI Scores at Intake (Week 1)

	BDI	BSI
Self-Hypnosis	29.5	1.81
Anti-depressant medication	34.2	1.92

Table 5: BDI and BSI Scores at Termination (Week 12)

	BDI	BSI
Self-Hypnosis	9.9	0.5
Anti-depressant medication	24	1.33

The case study by Lorieo and Torti⁹ using systemic hypnosis on depressed patients and their families demonstrated significant improvement in both the depressed patient and in the quality of the relationship. The hypnotherapy session between Guido, a 38-year-old male, and his depressed wife, Giulia, allowed them to openly discuss difficulties in their relationship and

previously unsaid emotions towards one another. The hypnotherapy made it possible for both of them to say what was on their minds and to restore their relationship. “Giulia’s sense of isolation, hopelessness, and depression was replaced with a renewed sense of purpose about her marriage.”⁹ In addition, Guido was able to understand why his wife was feeling certain emotions and allowed them to begin to improve their relationship.⁹

Another hypnotherapy session allowed a 61-year-old father, Antonio, and his 32-year-old son, Aldo, who no longer spoke to each other to restore their relationship by talking out their concerns and anxieties about one another. After the hypnosis session, they were able to finally reconnect. Hypnosis allows people to speak to each other in a very open and special way, unlike any other way method.⁹

A third hypnotherapy session was conducted between a 35-year-old female, Carla, her parents, and her sister. After about 5 hypnotherapy sessions between Carla and her family, Carla “reported feeling much better, finally having unloaded the burden of her troubled dishonest relationship with her family. She was not only able to finally smile spontaneously but she also began to share a sense of humor that never appeared before.”⁹

DISCUSSION

This systematic review investigated two RCTs and one case study for the effectiveness of hypnotherapy as a treatment for depression. These three studies demonstrated that hypnotherapy is an effective treatment for depression. The RCT by Alladin and Alibai⁷ confirmed that although CH and CBT generated a significant decrease in depressive symptoms at termination and follow-ups from baseline, CH produced significantly larger results than CBT at termination and both follow-ups. Unfortunately, because CH was composed of several components, it is impossible to determine which components had the greatest effects. The study also found that when

hypnotherapy was used in combination with CBT, it produced greater improvements in depressive symptoms than CBT alone.⁷

The study by Dobbin et al⁸ illustrated that self-hypnosis was significantly more effective than antidepressant medication in the treatment of depressed patients. However, patients were allowed to select whether they preferred to be in the hypnotherapy or anti-depressant medication group, which created a bias in the groups. Nonetheless, this bias was “addressed to some degree by adjusting for baseline factors in the analysis using multiple regression.”⁸ In addition, the hypnotherapy and medication groups that were randomized were too small to be analyzed. Developing a truly randomized control study between hypnotherapy and anti-depressant medication groups, rather than allowing for patient preference, would have produced more reliable and unbiased results.

The case studies on systemic hypnosis with depressed patients and their families revealed that hypnosis allowed individuals to openly and freely share thoughts and emotions with significant others in order to restore their relationship.⁹ Depression is thought of as an interpersonal disorder, rather than a personal struggle, and is influenced by relationship patterns and interactions. As a result, bringing all parties into the hypnosis session is a thorough and effective means of treating depression.

Depression is a chronic and debilitating disorder that affects millions of lives worldwide. An effective treatment for depression will allow many to return to normal living, free of depressive symptoms. There are numerous patients who refuse medication or whose antidepressant medication has adverse effects or dangerous interactions with other medications. In addition, antidepressants may take a great deal of time to produce a significant effect or may not have an effect at all. Regimens have to be adjusted and could take weeks to months to work.

In these instances, an alternative treatment, such as hypnotherapy, would be appropriate. In fact, the partially randomized preference design study by Dobbin et al demonstrated that significantly more patients preferred self-hypnosis to medication for the treatment of depression.

Hypnotherapy typically costs between \$75-\$125 per session, with sessions usually lasting between an hour and an hour and a half.¹³ Many insurance companies do not cover hypnosis services but will cover anti-depressant medications. Therefore, this poses a limitation on hypnotherapy as a treatment for depression unless patients are willing and able to pay for hypnosis services out-of-pocket.

CONCLUSION

After reviewing the two RCTs and one case study, the results demonstrated that hypnotherapy is an effective treatment for depression. The studies also revealed that hypnotherapy is more effective in treating depression than anti-depressants or cognitive-behavioral therapy. Future studies should be performed comparing hypnotherapy and anti-depressants using randomized groups rather than preference groups. This will eliminate bias and provide more significant results. Future studies would also benefit from using single aspects of cognitive hypnotherapy to treat depression in order to view the results of each specific method.

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